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#55

COUNCIL ON ETHICAL PRACTICE

AGENDA # 13

THE NEW YORK STATE NURSES ASSOCIATION
Report to the Board of Directors

Council on Ethical Practice
(Program/Dept./Individual/Unit)

March 30-31, 1989
(Date of Board Meeting)

Action Requested:

The Council on Ethical Practice requests approval by the Board of Directors of the Position Statement: Role of the Nurse With Respect to the Determination Not to Resuscitate (DNR).

Background and/or rationale for request:

The Council on Ethical Practice has revised the NYSNA position statement to conform to the new DNR legislation Public Health Law, Article 913, Section 2960, and to conform to the 1985 changes in the ANA Code For Nurses With Interpretive Statements.

If Applicable: Anticipated Financial Impact:
(Please explain in detail.)

None

Use additional paper if necessary.

ML0/ker
2/24/88

Martha L. Orr, MN, RN
Executive Director



Constituent of The American
Nurses Association

NEW YORK STATE NURSES ASSOCIATION
2113 Western Avenue, Guilderland, N.Y. 12084, (518) 456-5371

THE NEW YORK STATE NURSES ASSOCIATION
COUNCIL ON ETHICAL PRACTICE

Position Statement

Role of Nurse with Respect to
the
Determination Not to Resuscitate

OVERVIEW:

The New York State Nurses Association first issued a position statement on "Do Not Resuscitate" (DNR) orders in October 1983 with a revision in November 1986. This current revision reflects 1987 New York State DNR legislation in the Nurse Practice Act, Article 139, Title VIII of the Educational Law of New York State. It is also consistent with the American Nurses' Association's Code for Nurses with Interpretive Statements.

Nurses typically exert tremendous personal and professional energy to assist clients to maintain or regain health. The choice of DNR implies a positive action reflecting both the client's wishes during the last moments of life and also the limitations of medical technology.

POSITION:

The New York State Nurses Association's Council on Ethical Practice believes that the client has the right and responsibility to make health care decisions. In New York State, clients have the right to decide to have a Do Not Resuscitate order written when they are hospitalized. When the client is unable to decide, a person who can speak for the client's wishes should be consulted. If the client has formally named a surrogate, then the professional nurse must ensure that the surrogate's directives are implemented. In the absence of a surrogate, the nurse accepts the advocacy role for the incapacitated client and ensures that any DNR decision is determined by the health care providers only after careful deliberation and in accordance with NYS law.



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RECOMMENDATIONS: The New York State Nurses Association's Council on Ethical Practice makes the following recommendations in support of the professional nurse's role in Do Not Resuscitate decisions. The Council believes that professional nurses should:

1. encourage clients to consider the risks and benefits of cardiopulmonary resuscitation for themselves; determine whether or not they want resuscitation to be performed in the event of a cardiac or respiratory arrest; and to consider the risks and benefits of either action or inaction.
2. familiarize themselves with the law on Do Not Resuscitate in NYS and any policy within the employing institution on how the law is to be implemented.
3. urge periodic evaluation of the DNR decision-making process within the employing institution.
4. understand that a DNR order is consistent with the continuation of all other medical and nursing regimens, even life-sustaining regimens like chemotherapy.
5. support the right of clients to change their minds regarding a DNR decision.
6. support surrogate decision makers in this possibly difficult role.
7. collaborate with other health care providers and act as client advocates in ensuring that the client's wishes are being implemented.

REFERENCES

American Nurses Association (1985). Code for Nurses with Interpretive Statements. Kansas City, MO: American Nurses Association (G-56 12 M 7/85)

NYS Ch. Legislation (1987). Public Health Law, Article 29B, Section 2960

NYS Department of Health (1987). Do Not Resuscitate Orders. A Guide for Patients and Families. (pamphlet)

LAK/pcb
1/25/89

THE NEW YORK STATE NURSES ASSOCIATION REPORT TO THE BOARD OF DIRECTORS NURSING PRACTICE AND SERVICES PROGRAM

March 30-31, 1989

The Councils met at the Center for Nursing on February 27, 1989. For the first time, the two Councils met with the AIDS Advisory Committee to discuss issues and activities related to the HIV epidemic.

I. COUNCILS

A. Council on Nursing Practice

The Council met on February 27. They are presently revising "NYSNA's 1972 Position Descriptions" with assistance from the Councils on Nursing Education and Research. Their agenda included RCT update, unlicensed personnel, NYS Emergency Room Code changes, the 1989 Resolutions on the RCT, suggested resolutions for the 1989 Convention and NYSNA's Action Plan.

B. Council on Ethical Practice

The Council continued its discussion of the Resolutions on Registered Care Technologists and the Resolution on the Nursing Shortage and will finalize recommendations for the May Board of Directors meeting.

NYSNA's pamphlet on the "Relationship of the New York State Nurse Practice Act, the ANA Code For Nurses and the New York State Professional Conduct Laws" was reviewed. The ANA Code For Nurses component will be updated to conform to the revised code. Suggestions were made for updating the annotated bibliography.

The Council members finalized their update of NYSNA's "Position Statement on The Role of the Nurse with Respect to the Determination Not to Resuscitate (DNR)." Action is needed on this item.

II. CLINICAL PRACTICE UNIT

A. Ambulatory Care Nursing

The Executive Committee met on February 18. Discussion focused on the needs of ambulatory care nurses for process oriented nursing care plans, documentation and autonomy.

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B. Community Health Nursing

The Executive Committee met on January 24 and addressed problems related to the nurses' role with the homeless. Recommendations on the Resolution on Homelessness will be finalized for presentation at the May Board of Directors meeting. The possibility of co-sponsoring a convention offering (on the homeless) with the Council on Human Rights at the NYSNA 1989 convention was discussed.

C. Gerontological Nursing

This Executive Committee met on March 17, 1989. Main agenda items included developing recommendations on the 1989 Resolution on Nurses in Private Practice, an update on peer review for nurses in private practice, 1989 Convention unit activities and a discussion of Dr. Fielding's Quality Assurance Project.

D. Medical-Surgical Nursing

The Executive Committee met on March 7. Discussion focused on issues relative to the nursing shortage such as foreign nurses, agency nurses and the RCT issue. Committee members are concerned about the high failure rate on the NCLEX exam, and offer to help study alternatives to this problem.

E. Parent-Child Health Nursing

The Executive Committee met on February 14 and discussed options for implementing the 1988 Resolution on Free Access to Prenatal Care. The Committee recommended that NYSNA be opposed to the use of raw milk.

F. Psychiatric-Mental Health Nursing

This Executive Committee has not met since the last Board of Directors meeting.

G. School Health Nursing

The Executive Committee met on January 2 with the New York State Association of School Nurses to review the collaborative continuing education offering for orienting new school nurses to the role. The offering will be held in August and will be co-sponsored by NYSNA.

III. FUNCTIONAL UNITS

A. Direct Care Practitioners

This Executive Committee has not met since the last Board of Directors meeting.

B. Nurse Administrators and Managers

This Executive Committee has not met since the last Board of Directors meeting.

C. Nurse Entrepreneurs

This Executive Committee met on March 3, 1989. In response to the request of the unit members at the 1988 convention, the Executive Committee is planning to re-address the issue of reimbursement. It is considering the development of a pamphlet that will be an adjunct to the NYSNA booklet Nursing Entrepreneurship in New York State. The Executive Committee's comments on the draft of the Peer Review Program for Nurses in Private Practice will be added to those of other unit Executive Committees for a future draft. E. Joyce Gould, Director of the Legislative Program, gave an update on pending reimbursement legislation.

D. Primary Care Practitioners

The Executive Committee met on March 1, 1989 and focused on identifying needs of nurse practitioners as the new law and regulations are implemented for certification and prescriptive privileges. Members are concerned about the collaborative role in the law being interpreted by nurse practitioners and physicians as a supervisory role.

IV. COMMITTEES

A. Committee on Impaired Nursing Practice

The Committee met on January 23 completing the draft of a resource manual for district nurses associations. The drug "crack" will be included in the manual distribution this summer. The Committee is concerned about the 1990-91 deadline for the ANA addiction nursing certification exam. The National Consortium of Chemical Dependency Nurses does not have adequate quality standards, yet is being heralded an appropriate certifying agency. The Nurses' project has not been funded by any of the foundations that were approached.

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B. AIDS Advisory Committee

The Committee had its first meeting on February 27. The members reviewed pending bills which relate to the HIV epidemic and discussed future objectives. A joint meeting was held with the Councils on Nursing Practice and Ethical Practice. The Committee plans an intensive review of the NYS AIDS Statewide Plan which was recently published.

V. State Practice Issues

A. Registered Care Technologists (RCTs)

The following materials have been received on this issue and are attached:

- AMA's Regulatory, Workplace and Political Recommendations
- National Black Nurses' Association Position
- Intravenous Nurses Society Position

B. Prescription Writing Workshops

A three hour workshop in Prescription Writing is being conducted at seven sites around the state. The faculty are Jill Burk, PhD, RN, and Richard Fichtl, Pharmacist. Since it is difficult to determine the exact need for workshops, the Association had advertised in specific locales. A workshop flyer is attached.

C. AIDS Stress Study

There has been approximately an 18% return rate on the AIDS questionnaire. Texas A&M is currently coding the data.

E. HANYS

NYSNA continues to collaborate with the Hospital Association of New York State on the feasibility of a nursing documentation - computer assistance study.

F. Insurance Liability Committee

The first meeting of this committee is scheduled for late April. Markel Associates will be bringing a representative from a major underwriting company to the meeting.

G. Licensed Practical Nurses

Association counsel is seeking an additional meeting with SED counsel regarding NYSNA's response to the new draft regulations on LPN practice and intravenous therapy.

H. Nursing Intensity Weights

The Association will serve as consultants to the Department of Health in further evaluation of the AIDS service intensity weights. The Greater New York Hospital Association has proposed a time and motion study to contradict DOH's current SIW rates.

VI. Other Activities

Ask The Experts Column

The Nursing Practice and Services Program is participating in a regular practice column for Report. The topics which have been addressed to date are medication administration, responsibilities and abandonment.

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Director
Nursing Practice & Services

Gail K. DeMarco
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COUNCIL ON ETHICAL PRACTICE

COUNCILS

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Terri Cavaliere
Patricia Garman
Carol Gavan
Kathleen Nokes

Council on Nursing Practice

Nancy McGinn, Chairperson
Karen Heaphy
Glenda Marshall
Elizabeth Plummer
Anne Skelly

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Grace Daley, V. Chairperson
Anne Oboyski, Mbr. at Lrg.

Geronotological Nursing

Jean Sweeney, Chairperson
Frank DeLouise, V. Chairperson
Louise Bedford, Mbr. at Large

Medical-Surgical Nursing

Ann Sedore, Chairperson
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Gayle Newshan, Mbr. at Lrg.

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COUNCIL ON ETHICAL PRACTICE

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Peter Ungvarski

Constituent Forum
December 8-9, 1988
Agenda Item #12

AMERICAN NURSES' ASSOCIATION

Report on Recommendations from the
SNA Task Force on Nursing Shortage and RCT

From
Constituent Forum Executive Committee

To
Constituent Forum
December, 1988

The executive committee of the Constituent Forum met Wednesday, December 7 to review the recommendations and report of the SNA Task Force on Nursing Shortage and RCT. The chairperson of the Constituent Forum, Mary Beth Strauss, Ph.D., R.N., and the first vice-president, Virginia Trotter Betts, J.D., M.S.N., R.N., met in conference call November 29, 1988 with the SNA task force to finalize the report and recommendations. The executive committee agreed to forward the SNA task force recommendations to the Constituent Forum. They are as follows:

Regulatory Recommendations

- that state nurses' associations work with state boards of nursing to assure delegatory authority of nurses for nursing practice and on an interpretation of the proposed scope of RCT practice in relation to the potential violations of the practice of nursing.
- that state nurses' associations convene and/or maintain ongoing meetings with state boards of nursing to discuss regulation of unlicensed personnel for purposes of unity and resolving policy conflicts
- that state nurses' associations investigate and monitor activities of regulatory agencies which approve technical education programs in hospitals or other community settings

Workplace Recommendations

- that state nurses' associations utilize the shortage to promote collective action among nurses to address workplace issues
- that state nurses' associations without economic and general welfare programs examine their state's environment, including the activities of competing unions, and develop plans to assist nurses in addressing workplace issues
- that state nurses' associations utilize the information on workplace guidelines to build coalitions among nurses, including nurse executives and bargaining units, to combat the RCT and similar proposals as well as to enhance knowledge about workplace strategies

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Political Recommendations

- that the state nurses' associations conduct a political self-assessment and determine the level of involvement and resources necessary to defeat the RCT
- that consultation by the SNA be sought from the ANA Division of Governmental Affairs to assure a position of strength in those instances of questionable capabilities
- that state nurses' associations increase efforts to have nurses appointed to key regulatory positions

Additional Recommendations

- that staff be directed to work with the SNAs to determine the basic data elements regarding supply and demand of nurses and establish the methods and timetables to collect the information
- that SNAs be encouraged to include the topic of delegation in in-service programs
- that ANA provide the necessary central billing systems to enable the SNAs to conduct special membership projects

KSO:ds:cfrec
12/88

Attachment -

AMERICAN NURSES' ASSOCIATION

SNA Task Force on Nursing Shortage and RCT

Nursing Shortage: Regulatory Principles and Guidelines

Constituent Forum

December, 1988

Introduction

A shortage of personnel is one of the many reasons new occupational groups form. Other reasons include technology advances, cost containment, and changes in delivery needs. A shortage of nurses during the World War II period for example did lead to the growth of licensed practical nurse and the development of a medication aide resulted from shortages in rural areas. The American Medical Association argues a nursing shortage and a change in the focus of nursing as the reasons for the development of a new direct care provider, to be called a Registered Care Technologist (RCT). As ANA has stated, the RCT is unnecessary, duplicative and costly.

Serious consideration about the merits of any new occupation is necessary before the occupation is established. New groups tend to take on additional technology and knowledge and gradually become recognized in the work setting and by society. This leads to public protection of the "valued" service through legal regulation of individuals and then to the development of a professional identity; standards, ethics, and professional association. This paper describes various regulatory factors involved in implementing a new category of health care provider and the suggested regulatory principles to protect the practice of nursing from encroachment on its practice.

Mandatory Review Processes for New Providers

Because of the influx of new providers in the 1970's, many states have a mandatory review process for any new providers of a service: registered or licensed and in any field. The process can be administrative or legislative. In the latter instance, it is referred to as "sunrise" legislation. For nursing, the process provides a useful tool for studying, as part of public concern, any new direct care services similar to those by nurses.

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Based on information from the Fall 1988 State Practice Survey, the following 23 states have such processes in place.

Alabama	Mississippi
Arkansas	Nebraska
Arizona	New Jersey
Colorado	New York
Connecticut	Oklahoma
District of Columbia	Oregon
Florida	South Carolina
Georgia (only when new board required)	Tennessee
Hawaii	Virgin Islands
Kansas	Washington
Kentucky	Wyoming
Minnesota	

Two state statutes were examined: the Nebraska "Regulation of Health Professions Act" of 1985 and the South Carolina Chapter 18, "Review of Occupational Registration and Licensing" added in 1988 to Title I, Code of Laws of South Carolina, 1976, relating to Administration of the Government. The South Carolina Law is similar to an Arizona law.

Sunrise criteria guide state decisions about whether protection of the public is a primary concern. Parties interested in introducing a new provider submit an application to the state. The state then conducts an extensive internal investigation before submitting a proposal for legislative overview or public hearings.

The criteria used by the state indicates the rigor required of the applicant. The Nebraska statute reads:

- Sec 21. After January 1, 1985, a health profession shall be regulated by the state only when:
- (1) Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
 - (2) The public needs, and can reasonably be expected to benefit from, an assurance of initial and continuing professional ability; and
 - (3) The public cannot be effectively protected by other means in a more cost-effective manner.

The South Carolina language is similar but more detailed by considering a potential increase in costs. The state calls for such study as whether the service can be provided through existing agency or under the supervision of presently licensed practitioners; and, whether the practitioners will provide a service which would qualify for payment by a third party.

Attachment 5

AMERICAN NURSES' ASSOCIATION

SNA Task Force on Nursing Shortage and RCT

NURSING SHORTAGE: WORKPLACE GUIDELINES TO OPPOSE THE RCT

Constituent Forum
December, 1988

The nursing shortage has created a growing need and increasing interest among individual nurses in using workplace strategies to address practice and employment issues. As this fact has become more and more apparent, a number of organizations, including several competing unions, have voiced a willingness to provide the assistance nurses desire. It is, therefore, extremely important that state nurses' associations recognize and take advantage of opportunities to be responsive to the needs of individual nurses while strengthening the profession.

The following workplace guidelines for defeating the RCT and similar proposals are targeted for use by individual SNA members, especially staff nurses. This material will serve as the basis for a resource tool (e.g. fact sheet) which will be produced and made available to SNAs for distribution by February 1989.

Nurses work in a multiplicity of environments. Some work situations are characterized by a stable staff, experienced managers, and an openness to change. Other work situations are less ideal. The following guidelines are applicable to all work environments.

Workplace Guidelines For Defeating The RCT And Similar Proposals

Nurses all across the country successfully use workplace strategies to address a wide variety of economic and practice issues. There are a number of activities which can be undertaken by nurses in their particular work settings to minimize the likelihood that RCTs will be introduced.

Any time individual employees or a group of employees challenge an employer about the utilization of human resources, there is a degree of risk. The degree of risk will vary depending on the strategy being implemented and whether an individual is employed at-will or covered by a collective bargaining agreement. Consequently, nurses should be encouraged, before implementing any workplace strategies, to assess the levels of risk they and their colleagues are prepared to accept.

The following guidelines offer basic steps of action designed to garner sufficient support to defeat any proposal/attempt to introduce new bedside caregivers.

Organize nurses around the RCT issue.

- o Establish a steering committee to develop a specific plan of action, including desired outcomes and a mechanism for evaluating the effectiveness of various activities.
- o Select nurses to serve as floor/unit representatives on each shift. These individuals will assume responsibility for making certain that every nurse understands the issues at stake.

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- o Hold routine briefing sessions to apprise nurses of the most current information regarding implementation of the RCT proposal and relevant information on the nursing shortage.
- o Create special communication tools (e.g. newsletters, telephone trees) to maintain formal contact with nurses throughout the facility.

If nurses have been organized by the state nurses' association for collective bargaining, existing local unit committees and communication mechanisms can be used to accomplish these objectives

Orient nurses to be on the lookout for particular types of activities which could signal the creation of a pilot training program or the introduction of RCTs or similar personnel in your facility.

Nurses in teaching facilities need to be alert to:

- o Unannounced tours of the facility by "outside consultants."
- o The scheduling of meetings involving AMA representatives, the educational director, faculty, and key administrative staff of the facility.
- o The announcement that an existing training program is the subject of a special study.
- o The sudden availability of substantial resources designated for a new type of training program.

All nurses need to be alert to:

- o Tours of the facility by "outside consultants" whose primary focus appears to be on staffing assignments/arrangements for direct patient care.
- o Announcement of the hiring of a personnel consultant with little or no explanation of the individual's background or role and responsibilities.
- o Requests for nurses' input regarding nursing-related functions and duties which might be handled by different personnel.
- o Efforts to rewrite job descriptions and/or realign staff responsibilities and accountability across job categories.
- o Management-scheduled meeting(s) designed to solicit staff support for the introduction of a new type of personnel at the bedside.

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- o Inclusion of an AMA representative on the meeting agenda of the hospital administrative staff, medical staff organization, and/or hospital board of trustees.
- o Wide circulation of literature supporting the AMA proposal for the registered care technologist or similar concept.

Build a persuasive case against the training and hiring of RCTs or similar personnel. It is quite likely that AMA's proposal for the registered care technologist is only the first of many such proposals. Nurses need to be able to effectively articulate nursing's position regarding such personnel.

- o Delineate the major weaknesses of the RCT proposal, pointing out that the majority of these problems would also exist with similar proposals.
- o Collect the necessary data to refute the need for RCTs or similar personnel in your facility.
- o Draw attention to the real issues that must be addressed.
 - a. A proposal to implement a new category of health care personnel is not a solution to the nursing shortage
 - b. Nurses are not abandoning bedside nursing activities in pursuit of specialization and higher education.
 - c. The demand for nursing services has outstripped the supply of nurses.
 - d. Resolution of existing problems can only come about through a clear understanding of the complexity of factors contributing to the shortage of nurses.
 - e. National nursing organizations, working together, have delineated strategies to address the nursing shortage
 - f. There is evidence that nursing's solutions to the shortage are working in a variety of settings throughout the country.

Seek the cooperation and support of every physician affiliated with your facility. Keep in mind that most physicians are not members of the American Medical Association and many do not support the RCT proposal.

- o Make sure physicians are familiar with nursing's positions and the progress being made in implementing nursing's solutions to the shortage.
- o Encourage physicians to voice their opposition to the RCT and similar proposals and to express their support of nursing and its solutions to the nursing shortage.
- o Point out that the introduction of a pilot training process and the employment of RCTs or other poorly defined personnel at the bedside are likely to trigger very close scrutiny by the media.

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- o Emphasize that the introduction of minimally trained personnel at the bedside will compromise the quality of care, thus jeopardizing the reputation of the facility and the personnel associated with it.

Enlist the assistance of the director of nursing/nurse executive to convey nurses' concerns to other administrative staff and the board of trustees.

- o Provide the director of nursing/nurse executive with a written list of well-documented arguments against the introduction of RCTs or similar minimally trained personnel.
- o Make sure the director of nursing/nurse executive is fully aware of the short-term strategies for resolving the shortage of nurses supported by the national nursing organizations and the progress being made in implementing these strategies.
- o Encourage the director of nursing/nurse executive to find innovative ways to better acquaint hospital administrators and members of the board of trustees with nursing roles.

Increase the involvement of nurses on hospital decision-making and planning bodies.

- o Lobby for greater nurse representation at the executive level on administrative committees that are responsible for institutional planning, implementation, and evaluation, including strategic planning and short- and long-term policy making.
- o Establish professional practice committees with nursing and medical representation to monitor patient care outcomes and nurture professional relationships.
- o Use existing nurse representation on facility committees to raise concerns about staffing and the utilization of poorly defined/minimally trained bedside caregivers.
- o Take advantage of committee meetings and other group sessions to educate hospital trustees and other key decision-makers about the problems of the nursing shortage, inequities in nurses' salaries, non-nursing tasks performed by registered nurses, poor working conditions, etc. Such information will help focus greater attention on the real issues which should be addressed.
- o Encourage implementation of management practices which would increase RN involvement in development of institutional policies regarding nurses' involvement in clinical decision making, nurses' input in strategic planning and resource allocations, and nurses' participation in peer review.

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Use the collective bargaining process to address staffing concerns.
Where there is a collective bargaining contract:

- o Negotiate jurisdictional language or language stating that only bargaining unit members do bargaining unit work.
- o Negotiate language setting limitations on nurses performing non-nursing functions.
- o Negotiate language providing for staff nurse input into classification systems that determine nurse-to-patient ratios.
- o Use contractual committees to raise questions and concerns about the functions, practice, and supervision of RCTs or similarly proposed positions.

Examine personnel policies governing relationships between personnel in different departments and across categories.

- o Review job-specific information provided by or available from the employer, including the employee handbook and job descriptions for personnel providing nursing care.
- o Consider policies in relationship to actual practices. Unclear policies and/or inconsistent application of policies could facilitate the introduction of RCTs as well as impede efforts to oppose the RCT or similar proposals.
- o Become familiar with the procedure for handling grievances.

Solicit the support of other health care personnel who may also be experiencing shortages and, therefore, be vulnerable to substitution attempts.

- o Make sure other health care personnel are familiar with nursing's positions and the progress being made in implementing nursing's solutions to the shortage.
- o Encourage other health care personnel to voice their opposition to the RCT and similar proposals and to express their support of nursing and its solutions to the nursing shortage.
- o Point out that the introduction of a pilot training program and the employment of RCTs or other poorly defined personnel at the bedside are likely to trigger very close scrutiny by the media.
- o Emphasize that the introduction of minimally trained personnel at the bedside will compromise the quality of care, thus jeopardizing the reputation of the facility and the personnel associated with it.

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Urge staff development educators to refuse to develop or participate in training programs for RCT or similar minimally trained personnel.

- o Make sure staff development educators are fully aware of nursing's concerns regarding RCTs and any similar proposals.
- o Draw attention to the fact that the executive committee of the ANA Council on Continuing Education is urging staff development educators in hospitals across the country to refuse to develop or participate in proposed programs to train registered care technologists.
- o Point out that the introduction of a pilot training program and the employment of RCTs or other poorly defined personnel at the bedside are likely to trigger very close scrutiny by the media.
- o Emphasize that the introduction of minimally trained personnel at the bedside will compromise the quality of care, thus jeopardizing the reputation of the facility and the personnel associated with it.

Maintain the most current information on the RCT project and any similar proposals as well as shortage-related developments.

- o Set up a network with nurses in other facilities in the immediate area.
- o Contact the state nurses' association for the most current statewide and national news on the status of the RCT project and nursing shortage. In turn, keep the SNA informed of pertinent activities in your facility/area.

If it is apparent that your employer is preparing to train RCTs or similar health care personnel:

- o Formally inquire of the Nurse Executive, CEO, Medical Staff Organization, Housestaff Organization (if applicable), and Hospital Board of Trustees about the following:
 - a. Plans for the development of the program
 - b. Funding sources for the training program
 - c. Proposed clinical sites for trainees
 - d. Proposed clinical supervision for trainees
 - e. Hospital and nursing staff liability for negligent care provided by a trainee, i.e. overlapping assignments between permanent nursing staff and trainees
 - f. Legal authority for trainee practice
- o Notify the hospital risk manager and insurance carrier about liability concerns. Ask for opinions regarding the answers provided by the facility (or lack of answers) in response to questions about RCT training and supervision.

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- o Determine what quality control mechanisms and data exist to make sure clinical programs and patient outcomes will not suffer.

If it is apparent that your employer is preparing to introduce RCTs or similar health care personnel:

- o Formally request the Nurse Executive, CEO, Medical Staff Organization, Housestaff Organization (if applicable), and Hospital Board of Trustees to respond to the following questions:
 - a. Will the facility's liability insurance cover acts of a new, untested category of direct care provider?
 - b. How will existing staff be oriented to the preparation, functions, and role expectations of the RCT?
 - c. Who will make decisions about which clinical areas will be assigned to RCTs?
 - d. What plans will be made for day-to-day assignment and supervision of RCTs?
 - e. How will RCTs be factored into patient classification systems to determine staffing complements?
 - f. What funding will be used for RCT salaries and benefits? How will these allocations affect the compensation available for existing staff?
 - g. Will physician peer review include assessment of skill in supervision and utilization of RCTs?
- o Notify the hospital risk manager and hospital insurance carrier about nurses' concerns related to the introduction of RCTs. Ask for opinions regarding the answers provided by the facility (or lack of answers) in response to questions about RCTs.
- o Determine what quality control mechanisms and data exist to make sure clinical programs and patient outcomes will not suffer.

If RCTs or similar health care personnel are actually hired by your employer:

- o Document staffing concerns.
 - a. "Assignment Despite Objection" forms may be used in either contract or non-contract settings. (Note: It would also be appropriate to print the E&GW Cabinet's statement on accepting and rejecting assignments.)
 - b. Note on patients' charts every time an RCT is present. State the good faith belief that staffing is not safe enough to assure quality care. These notations are likely to draw the attention of the hospital's risk manager. Nurses may be directed to stop making such notations. Should this occur request that these directions be placed in writing with an accompanying rationale.
- o Make sure that quality control mechanisms are in place and that

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COUNCIL ON ETHICAL PRACTICE

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any new categories of caregivers will be included in the assessment process.

ULTIMATELY, HOWEVER, THE IMPLEMENTATION OF REALISTIC, WORKABLE SOLUTIONS TO THE SHORTAGE OF NURSES IS THE KEY TO DEFEATING THE RCT AND SIMILAR PROPOSALS.

Recommendations:

- o that state nurses' associations utilize the shortage to promote collective action among nurses to address workplace issues
- o that state nurses' associations without economic and general welfare programs examine their state's environment, including the activities of competing unions, and develop plans to assist nurses in addressing workplace issues
- o that state nurses' associations utilize the information on workplace guidelines to build coalitions among nurses, including nurse executives and bargaining units, to combat the RCT and similar proposals as well as to enhance knowledge about workplace strategies

LF:retadden.rpt

Attachment 5

AMERICAN NURSES' ASSOCIATION

SNA Task Force on Nursing Shortage and RCT

NURSING SHORTAGE: POLITICAL GUIDELINES TO OPPOSE THE RCT

Constituent Forum
December 1988

Background and Context

The introduction by the American Medical Association of a new category of bedside care provider, the registered care technologist (RCT), is a direct challenge to nursing. It can best be understood within the political context of a direct assault by organized medicine upon the growing influence and competitiveness of professional nursing. It must be met with a political response.

Guidelines:

Defensive Strategy

The first action must be defensive, and the first activity of that defense must be the gathering of information.

Each SNA must monitor for any signs that the RCTs are being introduced in their state. This includes both pilot projects and political activity. Rumors should be investigated and an "ear kept to the ground" for any signs of RCT activity. Each SNA must also monitor and analyze the message behind the public positions that are taken by individuals or state medical societies.

Upon discovering any signs of activity, information should be reported to Karen S. O'Connor, director of ANA's Division of Nursing Practice and Economics immediately, so that a coordinated effort can be organized. ANA will provide resources and consultation to a AMA-targeted state.

Offensive Strategy

It is the goal of the ANA that we defeat the establishment of RCTs, and that we maintain, unequivocally, the right of nursing to conduct its own professional affairs, thus allowing a more equitable relationship to develop with organized medicine. A possible strategy includes the introduction of nursing's own pre-emptive legislation, such as surprise legislation and the encouragement of discussion and dissension regarding the AMA's RCT position among health and medical providers. It is also a goal to hold the American Medical Association accountable for its public statements of support for nursing's solutions to the shortage.

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COUNCIL ON ETHICAL PRACTICE

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Preparatory Political Activities

There are certain fundamental political tasks necessary to the completion of any effective public policy program.

They include:

Nursing Education and Organization

Nurses are unified in their opposition to the RCTs. However, continuing education needs to occur to ensure that the AMA's propaganda does not succeed in confusing the issue. This education should be conducted among your own SNA membership and among other nursing organizations. Further, should a site in your state be chosen for a pilot project, nurses at that location should be educated on the subject.

Discussions between the SNA leadership and other nursing organizations concerning the RCT issue and nursing's response, should be initiated and maintained over whatever period of time is necessary. Most SNAs have held successful "nursing summits" to discuss the issue and have forged a unified plan for the state, as has ANA at the national level. A meeting of such a nature not only ensures communication and collaboration among nursing groups, but serves to head off attempts by the AMA to divide and conquer.

Interaction among nursing organizations to follow up on the initial meeting should be maintained, particularly with respect to monitoring any state developments.

SNA membership should be kept fully informed about the issue and motivated to participate in any activities the SNA deems appropriate. This can be done through your SNA publications, phone trees, and at district meetings. District presidents should be kept fully informed and asked to conduct programs on the RCT issue, the ramifications for the autonomous practice of nursing, and the nature of nursing's response.

Politically active nurses (members of the legislative committee, PAC, CDCs) should be thoroughly briefed on the issue so that they may incorporate nursing's response into their discussions with political figures.

Coalitions

Coalitions should be formed around this issue, whether or not there appears to be RCT activity in your state. This will not only serve as a preventive measure, but will offer an opportunity to educate others about professional nursing, and to form alliances that could be useful at other times around other issues.

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Organizations should be identified with potential interest in the outcome of this issue, and a "spin" given to the issue to indicate why their group should want to assist nursing in this effort.

Public Relations

Every news story needs a "hook," and the hook AMA is using is the shortage. Additionally, there is the hidden hook of the public's presumed interest in what physicians have to say.

Nursing has two potential hooks. The first is nursing's solutions for the shortage, about which you have received materials from ANA. The second is the quality of care issue.

In order to get this message across, the media must be contacted and interested in going with the story. This can be especially effective at the local level, where local nurses should be identified and briefed to carry the story to newspapers, shopper publications, and local talk shows. Additionally, letters to the editor from local nurses in local newspapers will be effective.

It is essential that all media activity be coordinated through the SNA. This will ensure that appropriate persons be identified as spokespersons and that they can be briefed on all of the major issues prior to any public outreach.

In addition to the media, another forum for public relations is public meetings. Clubs and organizations often seek speakers to fill out programs. SNA-identified and trained spokespersons can be offered to local organizations to explain the nursing shortage and the inadequacy of the AMA's response. Some of these meetings may take the form of debates with AMA representatives. Again, SNA-identification and training are essential to ensure that the proper message is delivered.

Self-Assessment

In order to determine the appropriate level of involvement for your SNA, it should prove helpful to first survey your existing resources.

Three basic questions need to be asked: where does your SNA fit in terms of the health care politics of your state; what are your internal capacities for carrying out these programs; and what are the points at which you must decide the appropriate level of your SNA's involvement?

State Health Care Politics

The first step is to review the political influence of your SNA and the state medical society, and try to come up with a relative assessment.

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COUNCIL ON ETHICAL PRACTICE

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You might find it helpful to chart the answers. The following questions need to be answered for both your SNA and the state medical society.

1. How much PAC money has each group donated in the past election? Special attention should be paid to PAC donations to members of committees that would hear the proposed ANA legislation, or that would have jurisdiction over any proposed AMA legislation.
2. What were the major successes and failures of each group in the past legislative session? Were failures indicative of any pattern of weakness in certain committees or among specific legislators? Can these weaknesses be exploited?
3. What is the assessment of influence of each of the groups in key committees? You may wish to ask the candid opinion of a neutral party. Do not assume that heavy PAC contributions from the AMA is an equation of influence, although it is always a factor.
4. What is the assessment of influence with the executive branch? Did either group support the present governor? How susceptible is health care administration in your state to politics? Does either group maintain good staff relations with the regulatory agencies? The board of nursing?
5. Does either group have good press relations? Can either group generate editorial comment in its favor? Does either have a press staff person or consultant?
6. How would a legislator answer the question, "Who speaks for nurses?"

In addition to the SNA and state medical society, other groups may play a key role in your state's health care politics. Rank these groups in order of influence with the legislature. Where would your SNA fall in this rank? If one of these groups is particularly powerful, answer the questions above for that group.

Internal Capacities

No SNA wishes to be in the position of over-committing its limited resources, despite the urgency of the problem. To determine the extent of your internal capacities to deal with the RCT problem, you should first survey these capacities realistically, and review potential ramifications to the political and objective realities of the SNA.

Resource Survey

There are three major resource areas you should review: finances, staff and volunteer time, and membership involvement

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SNA Structures

The ability of your SNA to respond will depend to a large extent on the structures you already have in place. The most relevant of these will be communications, political networks, and decision-making structures.

Communications - How do you communicate with your membership? With your leadership? How much lead-time is required to transmit a communication? Most SNAs have a regular means of communication such as a newsletter or other publication. How often is this printed? What happens in the interim?

There are other communication structures you may also have in place, such as telephone trees and district and local meetings. How can these be used to get the message out when it is time to educate and mobilize?

Political Networks - Many SNAs have political networks in place. These include legislative networks, PAC committees, and Congressional District Coordinators. Members involved in these networks are most likely to respond to the need to participate in this program. Their leadership should be included, wherever possible, in the RCT response, and the networks activated for information, education, and mobilization. Again, these networks have a track record which you should evaluate in determining how much responsibility to place with them.

Decision-Making Structures - SNAs have varying ways of arriving at decisions, involving a variety of officers and staff. It will be helpful to determine in advance which individuals and entities within your SNA must be kept informed and/or be a party to decision-making. How quickly can decisions be made? What approval do they require? Who is accountable to whom?

Potential Ramifications

Strong action usually evokes strong reaction. These reactions can be positive or negative. As part of your self-assessment, you should review these potentialities and determine how they would effect your SNA.

Undoubtedly, your relations with your state medical society will be changed. In some states, there has already been a positive reaction, and the medical societies have chosen not to participate in the AMA program. In most states, however, the medical societies will go along with the AMA, and will view your SNA's activities as a direct challenge.

This could be a good time to consider what you want from your relationship with your state medical society. You have probably already learned that you cooperated with them in the legislature. Undoubtedly, they are very powerful. If they choose to be vindictive, how can they hurt you? Is there anything they will oppose you on that they would not have ordinarily done so? Is there

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COUNCIL ON ETHICAL PRACTICE

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cooperation you will need soon on an agenda item? Are your relations collegial or paternalistic? Have they demonstrated respect for nursing?

Similar questions need to be asked about your relations with other members of the health community. Do they perceive nursing as an independent force to be dealt with unilaterally? Do they respect the medical society or do they resent it? Are there cooperative items on your agenda? How might they be affected?

Consideration should be given to your legislative agenda. If you have urgent items for the next session, review whether or not requesting favors from legislators and staff on the RCT issue will interfere with the accomplishment of that agenda.

Consider also the way in which you are viewed by the political establishment in your state. Will this professional "declaration of independence" enhance or hinder that stature? How much in debt are they to the medical society? Do they understand the relationship between nursing and medicine? Do they need education? Similar questions should be applied to the media in your state.

Finally, consider the ramifications in terms of nurses in your state. Will this serve as a unifying force under the leadership of your SNA? Will your members take pride in the SNA's leadership in response to this threat? Can potential members be recruited through this issue, providing another answer to the question, "What would the SNA do for me?"

Recommendations:

- o that the state nurses' associations conduct a political self-assessment and determine the level of involvement and resources necessary to defeat the RCT
- o that consultation by the SNA be sought from the ANA Division of Governmental Affairs to assure a position of strength in those instances of questionable capabilities
- o that state nurses' associations increase efforts to have nurses appointed to key regulatory positions

KSQ:ds:11/30/88

National Black Nurses' Association, Inc.

1011 14th Street, N.E.
Washington, D.C. 20002
(202) 898-5232

December 1988



Dear Colleague:

The National Black Nurses' Association, Inc. would appreciate having the enclosed Press Releases printed in your newspaper, magazine or used as a Community Service announcement on the radio, television.

If you need further information, please contact the National Office at the address above or call (202) 898-5232.

Sincerely,

Barbara Jeffers Patterson
Publicity Chairperson

Enclosures: Press Releases

BJP/nmc

D. Alice Georges
Bronx, New York
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Dele L. Alfred
Columbus, Ohio
1st Vice President

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Executive Director

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COUNCIL ON ETHICAL PRACTICE

NATIONAL BLACK NURSES' ASSOCIATION, INC.

1011 NORTH CAPITOL STREET, N.E.

WASHINGTON, D.C. 20002

Post Conference Press Release

CONTACT: (202) 898-5232

RELEASE DATE

PUBLICITY CHAIR: BARBARA JEFFERS PATTERSON

IMMEDIATE

PRESIDENT OF THE NATIONAL BLACK NURSES' ASSOCIATION, INC.,

C. Alicia Georges, RNC, MA, announced today that the National Black Nurses' Association, Inc., at its 16th National Institute and Conference, August 7-11, 1988 in Washington, D.C., voted unanimously to oppose the development of the Registered Care Technologist and to promote nursing personnel as Providers of Quality Nursing Care for Black Americans. The National Black Nurses' Association, Inc. is an organization of Black registered nurses, licensed practical/vocational nurses and student nurses. The Organization was founded in 1971. Two of the Association's objectives are to:

1. Define and determine nursing care for Black consumers for optimum quality of care by acting as their advocates.
2. Recruit, counsel and assist Black persons interested in nursing to ensure a constant procession of Blacks into the field.

For further information, contact:

Sadako S. Holmes, RN, MPH

Executive Director

National Black Nurses' Association, Inc.

1011 North Capitol Street, NE

Washington, D.C. 20002

(202) 898-5232

Attachments

#55

COUNCIL ON ETHICAL PRACTICE

NATIONAL BLACK NURSES' ASSOCIATION, INC.

RESOLUTION NO. 10: Promotion of Nursing Personnel as Providers of Quality Nursing Care for Black Americans.

WHEREAS, Black Americans continue to suffer excess death and disabilities as a result of chronic illness and infant mortality; and

WHEREAS, Black Americans experience these health problems due in part, to inadequate access to the health care system, and its providers; and

WHEREAS, Black nurses are well-prepared, culturally sensitive providers of health care; and

WHEREAS, The NBNA's goals are to increase the number and quality of nursing care providers for the Black community; and

WHEREAS, there already exists sufficient categories of licensed nursing care providers such as RNs, LPNs/LVNs; and the creation of a new category of health care providers, namely, registered care technicians (RCT) will further confuse health care consumers and divert resources for the education and training of these new health care workers; and

WHEREAS, the perilous health conditions of all Americans, particularly Black Americans, mandate that they be cared for by educationally well-prepared nurses; and

WHEREAS, the real solution to the nursing shortage requires equity in the rewards received by all licensed nurses. Be it therefore

RESOLVED, that the National Black Nurses' Association opposes the creation of the RCT and recommends the continuous utilization of currently licensed categories of nursing personnel.

Be it further RESOLVED that, NBNA work in collaboration with Black community organizations and other concerned groups in an effort to deter the efforts to initiate the development of this new category of workers.

Be it also RESOLVED that NBNA work to promote efforts to promote rewards for all categories of nurses, as well as the attractiveness of the nursing profession, so that more persons will desire positions in nursing, thereby contributing to the elimination of the nursing shortage.

ADOPTED August 11, 1988.



INTRAVENOUS NURSES SOCIETY, INC.

February 20, 1989

New York State Nurses Association
Juanita Hunter, President
2113 Western Avenue
Albany, N.Y. 12034

Dear Ms. Hunter,

The American Medical Association's intent to introduce Registered Care Technologists (RCT's) into the health care realm will fragment the entire health care system. Rather than assist in alleviating the increases demand for registered nurses, implementation will increase the burden already placed upon these professionals.

Concerns which remain unresolved and without an acceptable solution proposed by the AMA include:

1. Where will the qualified candidates for these positions come from, when currently vacancies exist in our nation's nursing schools?
2. What salary level will be adequate to attract qualified candidates when, despite increasing salaries of nurses, nursing positions remain vacant?
3. The AMA states the RCT will be responsible to physicians yet, they expect the registered nurse to supervise their actions.

Sanction of the RCT by state officials and health care facilities will decrease the quality of care rendered to residents of this state. Care which for years, has been effectively rendered under the auspices of the nursing community.

This program, at the taxpayers expense, will not produce cost effective health care. Funds which would be better utilized to improve our nations health care system would be squandered.

Nursing as a profession is mounting a united front against the RCT proposal.

Your support in the suppression of another level of health care personnel is solicited and appreciated.

Sincerely,

[Signature]
Deborah Caruso, R.N.
President, N.J. Chapter
Intravenous Nurses Society

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COUNCIL ON ETHICAL PRACTICE

PRESCRIPTION WRITING WORKSHOP

sponsored by

THE NEW YORK STATE NURSES ASSOCIATION

The 1988 NYS Nurse Practitioner Law & Regulations require that in order to be qualified for prescriptive privilege a nurse practitioner must have had pharmacology content on: writing prescriptions of controlled and non-controlled substances, New York's Generic Substitution Law and the State and Federal laws regarding prescriptive authority. The Prescriptive Writing Workshop will cover these topics as well as prescription writing. A pre and post-test will be given.

SPEAKER

Jill Burk, PhD, RN

Research Nurse Coordinator, Burn Center, NYH-Cornell University Medical College, New York City
Dr. Burk holds dual degrees in nursing and pharmacology. She has taught pharmacology to nurses in several universities.

For guaranteed groups NYSNA will be glad to discuss bringing this course to you. Contact: Gail DeMarco, NYSNA Nursing Practice & Services. 518/456-5371.

TIMES & PLACES

MARCH 22

1:30pm to 5:00pm

Arnonica M. Driscoll Center for Nursing
2113 Western Avenue, Guilderland, NY

APRIL 3

3:30pm - 7:00pm

New York State Nurses Association
9th floor, 1 Madison Avenue, New York City

APRIL 5

1:30pm - 5:00pm

201 Peck Hall, School of Nursing, Syracuse Univ.
610 E. Fayette St., Syracuse NY

APRIL 15

10:30am - 2:00pm

American Red Cross Auditorium
150 Amsterdam Ave., New York City

REGISTRATION

NYSNA MEMBER \$35.00
NON-MEMBER \$50.00

Space is limited in some of the workshop sites. Registrations will be taken on a first-come, first-served basis. Registration deadline for all workshops is 3 days in advance of the scheduled date. Registration fee includes materials and one break. A \$15.00 administrative fee will be deducted for all cancellations made one week in advance of date.

CONTACT HOURS

3.6 Contact Hours will be awarded following passage of the post-test. This program has been submitted to the New York State Department of Education for approval.

PRESCRIPTION WRITING WORKSHOP REGISTRATION FORM

For Office Use: W22
Rev'd _____ Due _____

NAME _____
ADDRESS _____
WORK PHONE _____ HOME PHONE _____

I will attend the following workshop: (please circle)

Center For Nursing Syracuse University NYSNA New York Office American Red Cross

NYSNA Member _____ NonMember _____ Enclosed is my payment of: _____

Make check payable to: New York State Nurses Association and return to NYSNA, 2113 Western Ave., Guilderland, NY 12084

AIDS UPDATE '89

REGISTRATION FORM

NAME _____ TITLE _____

ADDRESS _____

EMPLOYER'S NAME _____ EMPLOYER'S ADDRESS _____

HOME PHONE () _____ BUSINESS PHONE () _____

I Will Attend The Following Workshop (check one):

☐ Queens Village, NY, April 6-7 (W18) ☐ Staten Island, NY, April 24-25 (W19)

Please Check Your Specific Health Care Discipline:

☐ Registered Nurse ☐ Nurse Practitioner/Clinical Nurse Specialist
☐ Social Worker/Rehabilitation Counselor ☐ Occupational Therapist/Physical Therapist/Activities Therapist
☐ Dietician/Nutritionist

Enclosed is my check for \$ _____ for registration(s)

Make check payable to The New York State Nurses Association in the amount of \$40.00 per registration.
Please mail to: AIDS UPDATE '89, Organization Services, The New York State Nurses Association,
2113 Western Avenue, Guilderland, NY 12084.

The New York State Nurses Association • 2113 Western Avenue • Guilderland, New York 12084 • (518) 456-5371

Workshop
AIDS UPDATE '89
Please Read Re-Route to:
☐ Director of Nursing
☐ Continuing Education Director
☐ AIDS Program Coordinator

AIDS
AIDS UPDATE '89

At two-day comprehensive workshops for:

• Registered Nurses
• Nurse Practitioners/Clinical Nurse Specialists
• Social Workers/Rehabilitation Counselors
• Occupational Therapists/Physical Therapists/Activities Therapists
• Dieticians/Nutritionists

Antony's Queens Villages
The Harbor Club
Bayley-Selton Hospital

Sponsored by:
New York University Division of Nursing Education
AIDS Regional Education & Training Center
in conjunction with:
The New York State Nurses Association
through a grant from:
The US Department of Health & Human Services

COUNCIL ON ETHICAL
PRACTICE

New York City Chapter of NASW AIDS Task Force
The New York Counties Registered Nurses
Association, Inc., NYSNA District #11
New York State Dietetic Association
Nurses Association of the Counties of
Long Island, Inc., NYSNA District #11
Professional Nurses Association of
Suffolk County, NYSNA District #19

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COUNCIL ON ETHICAL PRACTICE

Martha L. Orr, MN, RN
Executive Director



Constituent of The American
Nurses Association

NEW YORK STATE NURSES ASSOCIATION
2113 Western Avenue, Guilderland, N.Y. 12084, (518) 456-5371

THE NEW YORK STATE NURSES ASSOCIATION
COUNCIL ON ETHICAL PRACTICE

Position Statement

Role of the Nursing Practitioner*
Re
The Determination Not to Resuscitate

- OVERVIEW:** The Council on Ethical Practice, in response to requests from its members, offers guidelines for the Role of the Nursing Practitioner in the care of the client when there has been a determination not to resuscitate (DNR).
- PREMISE:** The Council on Ethical Practice bases its position on the Nurse Practice Act, Article 139, Title VIII of the Education Law of New York State; the American Nurses' Association, Code for Nurses With Interpretive Statement, Tenet 1.6 The Dying Person which States:

As the concept of death and ways of dealing with its changes, the basic human values remain. The ethical problems posed, however, and the decision-making responsibilities of the patient, family, and professional are increased.

The nurse seeks ways to protect these values while working with the client and others to arrive at the best decisions dictated by the circumstances, the client's rights and wishes, and the highest standards of care. The measure used to provide assistance should enable the client to live with as much comfort, dignity, and freedom from anxiety and pain as possible. The client's nursing care will determine to a great degree how this final human experience is lived and the peace and dignity with which death is approached²;



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COUNCIL ON ETHICAL PRACTICE

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the NYSNA Position Statement, the Role of the Nursing Practitioner in the Pronouncement of Death³; and the Doctrine of Informed Consent which is based on the following postulates:

- a mentally competent adult has the right to determine whether or not to submit to medical treatment;
- the client/patient's consent, to be effective, must be informed consent;
- the client/patient has an object dependence upon his physician for the information upon which he relies in reaching his decision.⁴

RATIONALE: The Council recognizes that determinations not to resuscitate have long been a source of conflict and frustration for the nursing practitioner. The question of when to initiate or not initiate cardiopulmonary resuscitation is a complex one, stimulated by advances in technology and clouded by the lack of clear policies designed to guide decisions.

The Council maintains the position that the decision not to resuscitate is not a medical or nursing decision but a moral decision and that the decision, therefore, rests with the client or significant other. Decisions not to resuscitate are moral ones based on the client's beliefs about the value of life, the quality of life under given conditions and the acceptance or denial of the imminence of death.⁵

OPINION AND RECOMMENDATION: The Council encourages the establishment of an environment that preserves and enhances client autonomy and self-determination. When there is a determination not to resuscitate the nursing practitioner will continue to provide supportive and comfort care.⁶

The nurse has the responsibility to insure that the decision and its meaning have been discussed with the competent client and/or family. When there is any actual or suspected discrepancy between the expressed wishes of the client and/or family and the determination not to resuscitate, the nurse will document the fact in the client's record and communicate with the client's physician, appropriate others and/or agency.

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*The title Nursing Practitioner refers to the NYSNA Position Description title approved by the NYSNA Board of Directors, June 1972. It is recommended that this position description and title replace all existing descriptions pertaining to "General Duty Nurse," "Staff Nurse," "Primary Care Nurse," "Pediatric Nurse Practitioner," "Family Nurse Practitioner," etc. When designation of a clinical focus is desired, it should be included as an adjective, i.e., "Nursing Practitioner, Pediatrics," "Nursing Practitioner, Family Health Care," etc.

NOTE: The word client is to be used in place of "patient" since nursing clients are individuals, families, groups and communities. (Definition adopted from NYSNA Council on Education, Task Force on Behavioral Outcomes of Nursing Education Programs, 7/78.)

Approved by the NYSNA Board of Directors, 9/27/83

FTF/mk
10/4/83
11/05/86

REFERENCES

- 1 "Nurse Practice Act" - Education Law, Title 8, Articles 130 and 139 of McKinney's Consolidated Laws of New York Annotated.
- 2 American Nurses' Association. Code for Nurses With Interpretive Statements. Kansas City, MO: American Nurses' Association, 1976 (G-56).
- 3 New York State Nurses Association, Council on Nursing Practice. "Role of the Nursing Practitioner in Pronouncement of Death." Guilderland, NY: New York State Nurses Association, 1977 (mimeo).
- 4 Harper and James. The Law of Torts. (1968 supp.) Section 17.1 at 61.
- 5 Roland R. Yarling and Beverly J. McElmurry. "Rethinking the Nurses' Role in Do Not Resuscitate Orders: A Clinical Policy Proposal in Nursing." Advances in Nursing Science 5 (July 1983): 3.
- 6 New York State Nurses Association, "Role of the Nursing Practitioner in Pronouncement of Death." P. 1.

FTF/mk
10/4/83
11/05/86

#55

COUNCIL ON ETHICAL PRACTICE

AGENDA # 11

THE NEW YORK STATE NURSES ASSOCIATION

Report to the Board of Directors

Council on Ethical Practice
(Program/Dept./Individual/Unit)

May 18-19, 1988
(Date of Board Meeting)

Action Requested:

The Council on Ethical Practice requests that the NYSNA Board of Directors approve the revised "Statement on Abortion."

Background and/or rationale for request:

In view of the continuing controversy over this issue, the Council on Ethical Practice continues to support ANA's "Statement on Abortion" and has incorporated inclusive language and changes in the format to show consistency with other NYSNA position statements.

If Applicable: Anticipated Financial Impact:
(Please explain in detail.)

None.

Use additional paper if necessary.

MLD/ker
2/24/88

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THE NEW YORK STATE NURSES ASSOCIATION

Council on Ethical Practice

Position Statement on Abortion

OVERVIEW: The Council on Ethical Practice, in response to increased legislative activity concerning the abortion law as well as requests from the professional nursing community with regard to their rights and responsibilities and the rights of their clients pertaining to the issue of abortion, has studied and researched the issue and hereby presents its opinion and recommendations. This position statement essentially incorporates the American Nurses' Association's 1978 Statement on Abortion. (Attachment)

POSITION STATEMENT: The 1973 decision of the Supreme Court legalizing abortion remains a controversial issue. Advocacy groups on both sides of the issue, Pro-life and Pro-choice, remain locked in legislatures, courts, and media of the nation while debating their diverse and separate positions. In the midst of this national conflict are the nurses and those clients that are directly and actively involved in abortion procedures.

Both the nurse and the client have individual rights that are clearly supported in the ANA Code for Nurses with Interpretive Statements. In addition, the professional nurse has certain responsibilities that must be met while providing care to women who choose to have abortions. These rights and responsibilities can be described as follows:

CLIENTS' RIGHTS: Women have individual rights to decide if they will bear a child and under the law may decide to have a legal abortion. Women also have the right to information regarding alternatives. The patient who chooses to have a legal abortion has a right to competent, supportive care, both physical and psychological. The nursing profession accepts the obligation of providing competent nursing care as a major responsibility. The patient who chooses to have a legal abortion has a right to freedom from imposition of other's beliefs or judgmental attitudes. The patient who chooses to have a legal abortion has a right to information and counseling in an environment where there is mutual trust and personalized care before, during and after the abortion is performed. The patient who chooses to have a legal abortion has a right to receive care in an environment which provides privacy with specific nursing expertise.

NURSES' RIGHTS AND RESPONSIBILITIES: Professional nurses have a right to their own moral, ethical and religious beliefs. Nurses have a responsibility to give good care without imposing their personal beliefs on patients who choose to abort. The nurse has a right, except in an emergency situation where the client's needs will not allow for substitution, to refuse to participate in a voluntary termination of pregnancy. The nurse further has a right not to be subjected to coercion, censure or to discipline for reasons of such refusal. The nurse has a right and responsibility to seek employment in areas where the care of women choosing abortions will not be assigned. The nurse has the responsibility to give the

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COUNCIL ON ETHICAL PRACTICE

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patient objective information and to provide access to resources before, during and after a voluntary termination of pregnancy. The nurse has a right to an educational preparation which will enable one to meet the emotional, physical and psychological needs of women who are considering having, or have had a voluntary termination of pregnancy. The nurse has a responsibility to obtain this education.

RECOMMENDATION: The Council concurs with the guidelines for nursing actions with regard to abortion procedures presented in the 1972 issue of the NYSNA Legislative Bulletin which are listed below:

1. In recognition of an equal right to privacy and personal dignity, no patient should be subjected to prejudicial attitudes or undue pressure on the part of nurses regarding one's individual decision on abortion.
2. No individual patient or group of patients should be left unattended or uncared for in any stage of an abortion procedure. All efforts should be made by health administrators to provide the patient with services of registered nurses who do not object to the concept of abortion.
3. Registered nurses who object to participating in abortion procedures must make this fact known, in writing, to their employers.
4. Caring for the patient before or after an abortion is not regarded as participating in an abortion.
5. Registered nurses who object to direct counseling of the patient seeking abortion should refer the patient to the agency or provider where counseling can be obtained.

The Council on Ethical Practice maintains the position that abortion is a moral rather than a social or health issue and reaffirms its support of the 1971 legislation (A-1781, Wemple) protecting the rights of professional nurses who refuse to participate in any operation that violates an individual's conscience or religious beliefs.

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CEP/kac
5/10/88



AMERICAN NURSES' ASSOCIATION

Division on Maternal and Child Health Nursing Practice
Statement on Abortion

PROLOGUE

The rights and responsibilities of both clients and nurses are philosophical and ethical issues. The American Nurses' Association gives due consideration to both the needs and rights of clients and those of nurses.

CLIENT'S RIGHTS

A woman has the individual right to decide if she will bear a child, and under the law, she may decide to have a legal abortion. The patient who chooses to have a legal abortion has the right to competent supportive care, both physical and psychological. The client who chooses to have a legal abortion has the right to freedom from imposition of others' beliefs or judgmental attitudes. The client who chooses to have a legal abortion has the right to information and counseling in an environment in which there is mutual trust and personalized care before, during, and after the abortion is performed. The client who chooses to have a legal abortion has the right to receive care in an environment that provides privacy and specific nursing expertise.

NURSES' RIGHTS AND RESPONSIBILITIES

The nursing profession accepts the obligation of providing competent nursing care as the major responsibility. The nurse has a right to her own moral, ethical, and religious beliefs. Nurses have a responsibility to give good care without imposing their own personal beliefs on clients who choose to abort. The nurse has a right, except in an emergency situation in which the client's needs will not allow for substitution, to refuse to participate in a voluntary interruption of pregnancy. Nurses further have a right not to be subjected to coercion, censure, or discipline for reasons of such refusal. The nurse has a responsibility to give the client objective information and provide access to resources before, during, and after a voluntary interruption in pregnancy. Nurses have a right to an educational preparation that will enable them to meet the emotional, physical, and psychological needs of women who are considering having or have had a voluntary interruption of pregnancy. Nurses have a responsibility to avail themselves of the opportunities to obtain this education. Nurses who do not consider voluntary abortion ethical have a right and responsibility to seek employment in areas where they will not be assigned the care of women choosing abortions.

Adopted by the Executive Committee, Division on Maternal and Child Health Nursing Practice
June 12, 1978

Ann L. Clark, M.S., R.N., Chairperson
Ruth E. Redmann, M.A., R.N.
Carolyn Stoll, M.S., R.N.
Donna Nativio, M.S., R.N.
M. Elaine Wittmann, Ed.D., R.N.
Kathryn Barnard, Ph.D., R.N., F.A.A.N.

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COUNCIL ON ETHICAL PRACTICE

AMERICAN NURSES' ASSOCIATION

DIVISION ON MATERNAL AND CHILD HEALTH NURSING PRACTICE

Statement on Abortion

Endorsed by
NYSNA Council on Ethical Practice, 1/26/79

PROLOGUE

The rights and responsibilities of both clients/patients and of nurses are philosophical and ethical issues. The American Nurses' Association gives due consideration to both the needs and the rights of clients/patients and of the nurse.

PATIENTS' RIGHTS

Women have individual rights to decide if they will bear a child and under the law may decide to have a legal abortion. Women also have the right to information regarding alternatives.* The patient who chooses to have a legal abortion has a right to competent, supportive care, both physical and psychological. The nursing profession accepts the obligation of providing competent nursing care as a major responsibility. The patient who chooses to have a legal abortion has a right to freedom from imposition of other's beliefs or judgmental attitudes. The patient who chooses to have a legal abortion has a right to information and counseling in an environment where there is mutual trust and personalized care before, during and after the abortion is performed. The patient who chooses to have a legal abortion has a right to receive care in an environment which provides privacy with specific nursing expertise.

NURSES' RIGHTS AND RESPONSIBILITIES

The nurse has a right to her own moral, ethical and religious beliefs. She has a responsibility to give good care without imposing her own personal belief on patients who chose to abort. The nurse has a right except in an emergency situation where the patient's needs will not allow for substitution, to refuse to participate in a voluntary interruption of pregnancy. She further has a right not to be subjected to coercion, censure or to discipline for reasons of such refusal. The nurse has a right and responsibility to seek employment in areas where she will not be assigned the care of women choosing abortions. The nurse has a responsibility to give the patient objective information and provide access to resources before, during and after a voluntary interruption of pregnancy. The nurse has a right to an educational preparation which will enable her to meet the emotional, physical and psychological need of women who are considering having, or have had a voluntary interruption of pregnancy. The nurse has a responsibility to avail herself of the opportunity to obtain this education.

Adopted by the Maternal-Child Health Division Executive Committee, 6/12/78.

*Revised by the Council on Nursing Practice to include this sentence.

Approved by the ANA Board of Directors, 4/5-6/79

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ABOUT THE ABORTION ISSUE:

Due to increased legislative activity concerning the 1970 liberalized abortion law, NYSNA wishes to reaffirm its position on this matter.

In 1970, NYSNA endorsed total repeal of the abortion law, not reform of the law. This position was based on the belief that abortion is a moral, rather than social or health issue.

In addition, NYSNA supported the law passed in 1971 (A-1781 Wemple) protecting the rights of those who refuse to participate in any operation which is contrary to their religious beliefs or conscience.

The following guidelines are offered:

1. In recognition of an equal right to privacy and personal dignity, no patient should be subjected to prejudicial attitudes or undue pressure on the part of nurses regarding her individual decision on abortion.
2. No individual patient or group of patients should be left unattended or uncared for in any stage of an abortifacient procedure. All efforts should be made by health administrators to provide the patient with the services of registered nurses who do not object to the concept of abortion.
3. Registered nurses who object to participating in abortifacient procedures should make this fact known, in writing, to their employers as soon as possible.
4. Caring for the patient before or after an abortifacient procedure is not regarded as participating in an abortifacient procedure.
5. Registered nurses who object to direct counseling of the patient seeking abortion should refer the patient to the agency or department where counseling can be obtained.

EXCERPT FROM NYSNA LEGISLATIVE BULLETIN - ISSUE NO. 14, 4-27-77, PAGE 1.

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COUNCIL ON ETHICAL PRACTICE

AGENDA #11

THE NEW YORK STATE NURSES ASSOCIATION

Report to the Board of Directors

Council on Ethical Practice
(Program/Dept./Individual/Unit)

May 18-19, 1988
(Date of Board Meeting)

Action Requested:

The Council on Ethical Practice requests that the NYSNA Board of Directors approve the revised position statement entitled, "Ethics Committees and the Role of the Professional Nurse."

Background and/or rationale for request:

The Council members believe that with the advancement of medical technology and the increasing complexity of health care issues in an environment of cost-containment and personnel shortages, it was necessary to revise this position statement.

If Applicable: Anticipated Financial Impact:
(Please explain in detail.)

None.

Use additional paper if necessary.

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2/24/88

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THE NEW YORK STATE NURSES ASSOCIATION

COUNCIL ON ETHICAL PRACTICE

POSITION STATEMENT

Ethics Committees
and
The Role of the Professional Nurse

OVERVIEW:

The fast-paced advancement in medical technology coupled with the reality of economic and human resource limitations create complex health care issues. Decision making and policy development regarding health care delivery raise serious questions with ethical dimensions. Consideration of these questions requires an interdisciplinary perspective which includes nursing.

In 1984, the ANA House of Delegates, aware of the increasing need for discussion and resolution of the myriad ethical problems in patient care, institutional policy and public health, adopted the following motion:

ANA encourages state nurses' associations to promote nurses' active participation in the development, implementation and evaluation of formal mechanisms for multi-disciplinary institutional ethical review such as institutional ethics committees.

In an effort to assist state nurses' associations and the individual professional nurse to implement action based on this motion, the ANA Committee on Ethics developed Guidelines on Mechanisms Through Which State Nurses' Associations Consider Ethical Issues and Concerns (1985) and Guidelines for Nurses' Participation and Leadership in Institutional Ethical Review Processes. (1985a)

RATIONALE:

The NYSNA Council on Ethical Practice believes that the professional nurse has both the right and the responsibility to participate in interdisciplinary institutional ethical review processes, including ethics rounds, membership on ethics committees and other forums for consideration of ethical issues. Using the ANA's Code for Nurses with Interpretive Statements (1985) as a framework, nurses bring an unique perspective to decision-making processes based on the nature of their expertise and on their obligations to and relationships with patients, families, other health professionals and society. (Rosa, 1986)

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COUNCIL ON ETHICAL PRACTICE

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RECOMMENDATION:

The NYSNA Council on Ethical Practice makes the following recommendations in support of professional nurses' involvement in the ethical review process and ethics committees in their own practice setting:

1. The study of ethical reasoning and ethical decision making in health care should be an integral component of all nursing curricula and of continuing education programs.
2. The Code for Nurses with Interpretive Statements (1985) provides guidance for conduct and relationships in carrying out nursing responsibilities consistent with the ethical obligations of the profession and with high-quality nursing care. The Code for Nurses should be widely read, taught and considered, and is available free of charge from ANA.
3. Professional nurses should initiate the establishment of an ethical review process in their own practice setting, if it is not already established.
4. Professional nurses should participate in interdisciplinary ethical review processes.
5. Professional nurses should consult the literature for further information and guidance about the development of ethics committees.
6. The NYSNA Council on Ethical Practice is available for consultation and support for professional nurses who want to increase their involvement in ethical review processes in their own practice setting.

REFERENCES

- American Nurses' Association. (1985). Code for nurses with interpretive statements. Kansas City, MO: Author.
- American Nurses' Association Committee on Ethics. (1985). Guidelines for nurses' participation and leadership in institutional ethical review processes. Kansas City, MO: American Nurses' Association.
- American Nurses' Association Committee on Ethics. (1985). Guidelines on mechanisms through which state nurses' associations consider ethical issues and concerns. Kansas City, MO: American Nurses' Association.
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COUNCIL ON ETHICAL PRACTICE

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Executive Director



Constituent of The American
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THE NEW YORK STATE NURSES ASSOCIATION COUNCIL ON ETHICAL PRACTICE

POSITION STATEMENT

Role of the Professional Nurse on Ethic Committees

OVERVIEW: The Council on Ethical Practice believes that the American Nurses' Association Code for Nurses With Interpretive Statements serves to inform both the nurse and society of the profession's expectations and requirements in ethical matters. The Code and the Interpretive Statements provide a framework for the nurse to make ethical decisions and discharge responsibilities to the public, to other members of the health team, and to the profession. Therefore, this paper is concerned with the role and responsibility of professional nurses participating on interdisciplinary committees addressing the ethical dimension of social and health policy issues.

- PREMISE:**
1. Society's trust in a profession is invested to the extent of that profession's acceptance of responsibility for, and accountability to, the best interests of the public which it serves.
 2. The development of a code of ethics is an essential characteristic of a profession and provides one means for the exercise of professional self-regulation.
 3. Nurses make ethical judgments on two levels:
 - as an individual practitioner responsible for one's own act; and
 - as a member of a health facility's Interdisciplinary Committee on Ethics influencing policy decision and contributing to change.



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COUNCIL ON ETHICAL PRACTICE

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4. The advances in health science and technology have multiplied the situational conflicts confronting the nurse.

RATIONALE: Policy development affects groups of patients, resource allocations, structures and outcomes of health care delivery. There is, therefore a need for nurses to participate in the ethical decision-making process which affects treatment of patients. In addition to recognizing ethical principles applicable to decisions, there is also the need to clarify the nurse's responsibility to participate in making such decisions. The professional nurse is in an unique position to identify, and needs to articulate, the interests of patients, and to represent such interests to the Interdisciplinary Committee on Ethics.

POSITION STATEMENT: The professional nurse has the right and responsibility to participate in the Interdisciplinary Committee on Ethics; inherent in the role is the recognition that the professional nurse has obligations to one's self, to the profession, and to society.

Based on the following assumptions: 1) that ethical principles are constant; 2) that ethical dilemmas are changeable; 3) that committees have a variety of purpose, structure, membership, roles and activities which change over time; and finally 4) that regularly scheduled ethical rounds are vital to the activities of the committee.

It is therefore recommended that:

- RECOMMENDATION:**
1. Committees on Ethics should include representatives of the professions, pastoral care, ethicists, philosophers, as well as consumers;
 2. Professional nurses should be instrumental in the establishment of ethical committees in any setting where such service is not provided;
 3. All Committees on Ethics should be standing committees;
 4. The professional nurse representative(s) on ethical committees should be selected for his or her interest and knowledge of ethics and nursing issues;

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5. Professional nurses should actively participate in ethical rounds;
6. The study of ethics should be an integral component of all basic nursing curricula.

Approved by the NYSNA Board of Directors, April 29-30, 1981

REFERENCES:

- American Nurses' Association. Code for Nurses With Interpretive Statements. Kansas City, MO: American Nurses' Association, (G-56) 1978, p. 1.
- Stanley, Teresa. "Nursing." Encyclopedia of Bioethics, Vol. 1, (Reich, Warren T., Editor) New York, NY: The Free Press, MacMillan Publisher, 1975, pp. 1138-46.

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COUNCIL ON ETHICAL PRACTICE

AGENDA # 11

THE NEW YORK STATE NURSES ASSOCIATION

Report to the Board of Directors

Councils on Nursing Practice and Ethical Practice
(Program/Dept./Individual/Unit)

May 18-19, 1988
(Date of Board Meeting)

Action Requested:

Approval of the revised "Opinion: The Role of the Professional Nurse Re: Human Immunodeficiency Virus (HIV) Infection and Acquired Immunodeficiency Syndrome (AIDS)."

Background and/or rationale for request:

The original statement was written in 1982. Since understanding and knowledge regarding HIV/AIDS has progressed rapidly since the early 1980's, a revision was necessary.

If Applicable: Anticipated Financial Impact:
(Please explain in detail.)

None.

Use additional paper if necessary.

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2/24/88

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The New York State Nurses Association

Council on Nursing Practice
Council on Ethical Practice

Opinion: The Role of the Professional Nurse

Re: Human Immunodeficiency Virus (HIV) Infection and Acquired Immunodeficiency Syndrome (AIDS)

Overview: The NYSNA Council on Nursing Practice and the Council on Ethical Practice in response to the concerns of members of the nursing profession regarding the care of clients with HIV infection and AIDS, have studied and researched the issue. Acquired Immunodeficiency Syndrome (AIDS) as defined by the Centers For Disease Control (CDC) is only one illness in the vast spectrum of diseases caused by the Human Immunodeficiency Virus (HIV). The CDC classification system for HIV infection includes a wide spectrum of conditions from asymptomatic states to acute infections. (CDC)

Since its appearance in the United States in 1980, persons with HIV infection and AIDS have been clustered in certain geographical areas. Although the disease has been observed worldwide and is considered an epidemic in the United States, New York State continues to report the greatest number of cases. Many health experts predict that there will be between 200,000 and 300,000 active cases of AIDS and 1.5 million persons with HIV status in the nation by the year 1991.

Due to the nature of the illness and the groups primarily affected, there has been considerable public anxiety generated. Reports have been issued regarding individuals avoiding clients with positive HIV status or AIDS and about the maltreatment, or lack of treatment, these clients have received from health care staff in hospitals, clinics and home care settings.

Basic Premises: The American Nurses Association's Code For Nurses with Interpretative Statements provides the framework for ethical decision making in nursing. The Code is based on the belief that nursing encompasses the promotion and restoration of health, the prevention of illness and the alleviation of suffering. Tenet One of the Code states that "the nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by consideration of social or economic status, personal attributes, or the nature of the health problem." (ANA)

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COUNCIL ON ETHICAL PRACTICE

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In New York State, professional nurses in accordance with the Nurse Practice Act, Article 139 of Title VIII of the State Education Law, are responsible for "diagnosing and treating human responses to actual or potential health problems through such services as casefinding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being...". (SED)

The Rules of the New York State Board of Regents which relate to definitions of unprofessional conduct state in Part 29.2 (1) that "abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care" is considered unprofessional conduct. (SED)

Clearly then, it is a moral, legal and professional responsibility of nurses to care for persons with HIV infection and AIDS. In addition, clients are entitled to confidential health care. This right has long been respected by professional nurses. In order to give holistic care, professional nurses must have access to all information necessary to deliver quality nursing care while assuring and maintaining the client's confidentiality.

The New York State Nurses Association is committed to assisting professional nurses in obtaining the information needed to care for HIV/AIDS clients and to understand their rights and responsibilities to this client population. In 1987, the NYSNA Board of Directors sent written communication to all Deans/Chairpersons of nursing programs and to all Directors of Nursing in health care facilities in the state urging that appropriate educational programs regarding HIV infection and the nursing care of these persons be developed for nursing students and professional nurses.

Opinion: It is the opinion of the NYSNA Councils on Nursing Practice and Ethical Practice that:

1. professional nurses have been and will continue to be responsive to the health care needs of persons with HIV/AIDS and the multifaceted needs of their families;
2. professional nurses are legally and ethically responsible to provide and assure that clients with a diagnosis of HIV infection and/or AIDS have access to and receive appropriate care;
3. health teaching and health counseling for the client, family and significant others should include the recommended precautions to limit the spread of this disease and the necessary precautions for caring for persons with HIV infection/AIDS;
4. professional nurses have both the obligation and expertise to assist other health care providers and the public at large in understanding this health problem, the risk behaviors associated with HIV transmission, the particular needs of persons with HIV infection/AIDS and the principles and techniques of providing care; and

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5. appropriate precautions for caring for clients with HIV infection/AIDS must be taken by nurses to maintain the low risk to caregivers and that the necessary precautionary materials and devices be readily available to nurses and other caregivers.

The Council on Nursing Practice and the Council on Ethical Practice strongly advise all professional nurses in New York State to maintain an updated knowledge base regarding the nursing needs of persons with HIV infection and AIDS and to follow the specific recommendations regarding universal precautions and the prevention of transmission which have been established by the New York State Department of Health and the Centers for Disease Control. (State, CDC) The Councils recommend that any professional nurse who needs assistance or clarification in this area of nursing practice contact the New York State Nurses Association for assistance.

REFERENCES

- Acquired immune deficiency syndrome. (1983, March 30). State of New York Department of Health Memorandum. Series 83-27.
- American Nurses' Association. (1985). Code for nurses with interpretive statements (2nd revision). Kansas City, MO: Author.
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COUNCIL ON ETHICAL PRACTICE

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THE NEW YORK STATE NURSES ASSOCIATION

EXECUTIVE COMMITTEE
OF THE FUNCTIONAL UNIT
OF DIRECTORS, ASSOCIATES AND ASSISTANTS
NURSING PRACTICE AND SERVICES

Opinion: The Role of the Nursing Practitioner*

Re: Acquired Immune Deficiency Syndrome (AIDS)

OVERVIEW:

The Executive Committee of the Functional Unit of Directors, Associates and Assistants, Nursing Practice and Services, in response to widespread concern of the nursing profession regarding the care of clients with AIDS studied and researched the issue. Acquired Immune Deficiency Syndrome is defined as a disease, at least moderately predictive of a defect in cell mediated immunity often characterized by *Kaposi's sarcoma* (K5), *Pneumocystis carinii* pneumonia (PCP) and other serious opportunistic infections (OI) in persons with no known cause for diminished resistance to the disease.

AIDS is a disease affecting nationwide approximately 2000 individuals. AIDS cases have been clustered in certain geographic areas. More than 50% of cases have been reported from New York State.

Due to the nature of the illness and the groups affected, there has been much anxiety generated among the public by the various media. Reports have been issued regarding individuals avoiding AIDS patients and about the maltreatment, or lack of treatment, such clients have experienced in hospitals and clinics by professional staff including the registered professional nurse.

**Purpose
and
Rationale:**

The American Nurses Association Code for Nurses with Interpretive Statements provides the framework for ethical decision making in nursing. The Code is based on the belief that nursing encompasses the promotion and restoration of health, the prevention of illness and the alleviation of suffering. Tenet #1 of the Code states: *The Nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by consideration of social or economic status, personal attributes, or the nature of the health problem.*



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Professional nurses, in accordance with the *Nurse Practice Act of New York State* as contained in Article 139 of Title VIII of the Education Law are responsible for

diagnosing and treating human responses to actual or potential health problems through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being...

The Rules of the New York State Board of Regents Relating to Definitions of Unprofessional Conduct states in Part 29.2(1) that *abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care...is considered unprofessional conduct.*

OPINION:

It is the opinion of the Executive Committee of the Functional Unit of Directors, Associates and Assistants, Nursing Practice and Services, that: the nursing profession should provide and assure that AIDS clients receive appropriate care. Health teaching and health counseling for the client, family or significant other as well as the public should include the appropriate precautions necessary for caring for an AIDS client. Professional nurses have both the obligation and expertise to assist other health care providers in understanding this health problem, the particular needs of clients experiencing this health problem, and principles and techniques of appropriate care. Specific precautions have been established by the State of New York Department of Health Memorandum-Public Health Series 83-27 - *Acquired Deficiency Syndrome*.

*The title *Nursing Practitioner* refers to the NYSNA Position Description title approved by the NYSNA Board of Directors, June 1972. It is recommended that this position description and title replace all existing descriptions pertaining to "General Duty Nurse," "Staff Nurse," "Primary Care Nurse," "Pediatric Nurse Practitioner," "Family Nurse Practitioner," etc. When designation of a clinical focus is desired, it should be included as an adjective, i.e., "Nursing Practitioner, Pediatrics," "Nursing Practitioner, Family Health Care," etc.

Approved by the NYSNA Board of Directors, September 21, 1983

-3-

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American Nurses' Association. *Code for Nurses with Interpretive Statements*, (G-56), Kansas City, Mo. 1973.

New York State Nurses Association. *The Nurse Practice Act of New York State*, Guilderland, N.Y., 1981.

Official Compilation of Codes, Rules and Regulations of the State of New York. Chapter 1, Board of Regents, Title 8, Education, Part 17 "Disciplinary Proceedings in the Profession."

Chapter 1, Board of Regents, Title 8, Education, Part 28, "Determination of Good Moral Character in the Professions."

Chapter 1, Board of Regents, Title 8, Education, Part 29 "Unprofessional Conduct," 1978.

State of New York Department of Health Memorandum. Public Health Series, "Acquired Immune Deficiency Syndrome (AIDS)," March 30, 1983.

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COUNCIL ON ETHICAL PRACTICE

THE NURSING PRACTICE AND SERVICES BOARD

REPORT TO THE BOARD OF DIRECTORS

NURSING PRACTICE AND SERVICES BOARD

May 19-21, 1988

All the organizational units (Councils, Clinical Practice Units and Functional Units) staffed by the Nursing Practice and Services Board met separately and together on May 19 and 20, 1988 at the Council on Nursing Practice and Services Board meetings. The units reviewed continuing education program activities for the 1988 Convention, updated their areas of responsibility in the 1988 Action Plan, discussed current practice issues, reviewed the main points of the 1988 Convention, reviewed the 1988 Report and the Nursing Practice Board's 1988 Report, and discussed other issues of all and practice concerns related to the nursing care of persons with HIV/AIDS.

I. COUNCILS

A. Council on Ethical Practice

The Council is completing its work on the DNA position statement to incorporate recent state legislation. Plans were finalized for the presentation on DNA and Health Care Proxy for the NISNA Convention. This Council joined the Council on Nursing Practice in developing a nurses' rights pamphlet. The Council has revised its position statement on the Role of the Professional Nurse on Ethics Committee and the Statement on Abortion. Action is needed on these items.

B. Council on Nursing Practice

The Council finalized its discussions regarding the 1987 Convention Resolutions on funding for nursing services and improving practice conditions. The members continue to collaborate with the Council on Ethical Practice in developing a nurses' rights pamphlet. The Council has revised its position statement on "The Role of the Professional Nurse Re: Human Immunodeficiency Virus (HIV) Infection and Acquired Immunodeficiency Syndrome (AIDS)." Action is needed on this item.

II. CLINICAL PRACTICE UNITS

A. Community Health Nursing

This Clinical Practice Unit worked on finalizing its Convention program on the nurse's role with the homeless. The Executive Committee members are discussing the possibility of a clinical exchange project at Convention. The possibility of a future workshop on immunizations was

COUNCIL ON ETHICAL PRACTICE

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B. Gerontological Nursing

An effort is planned to encourage retired nurses as well as gerontological nurses to attend the Convention and business meeting in October. The Committee is working on peer review and quality assurance projects with the assistance of Dr. Jane Fielding.

C. Medical-Surgical Nursing

The Unit is concerned about the number of persons who are not adequately immunized. Initial thoughts for an immunization workshop were discussed in a joint meeting with the Community Health Clinical Practice Unit.

D. Parent/Child Health Nursing

The Parent/Child Health Nursing Clinical Practice Unit made plans for the 1988 Convention Business Meeting. They expressed opposition to the proposed midwifery practice act. They continue their interests in prenatal care for all women, immunization programs and women's health issues.

E. Psychiatric-Mental Health Nursing

The Executive Committee continues to discuss strategies related to passage of Exempt Clause Repeal. In addition, they are discussing peer review and its relationship to third party reimbursement; identifying a relevant definition of supervision and developing a Convention Program on Patient Violence.

F. School Health Nursing

The School Health Nursing Executive Committee will meet with the New York State Association of School Nurses to explore a joint conference to orient new school nurses to state/federal rules and regulations and expectations for promotion of health in school age children.

III. FUNCTIONAL UNITS

A. Direct Care Practitioners

The Executive Committee spent time discussing preparation for activities at the Business Meeting to be held at Convention. They shared great concern regarding the need for promoting a positive image of nursing and will use a video on this topic prior to their Business Meeting. This issue is to be the priority the Unit will focus on during 1988-89.

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COUNCIL ON ETHICAL PRACTICE

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B. Nurse Administrators and Managers

The Executive Committee expressed concern over the lack of interest of their peers in the Unit and will be working to increase interest at Convention. The Executive Committee joined the Psychiatric/Mental Health Nursing Clinical Practice Unit's Executive Committee in working on the development of a definition of professional supervision.

C. Primary Care Practitioners

The Executive Committee discussed the status of the prescriptive privilege legislation. There was opposition to any legislation being presented that would not include Article 28 facilities. Plans for the Convention Business Meeting were also discussed.

V. COMMITTEE ON IMPAIRED NURSING PRACTICE

The Committee has been constituted and held its first meeting on May 3, 1988. Its members are Miriam Aaron (Chairperson), Brenda Haughey, Susan Kemble, Georgine McCabe and Karen Wolcott with liaison representatives from the Nurse Anesthetist Association, LPN, Inc., and the Committee on Professional Assistance. The Committee is awaiting a response from the State Board for Nursing regarding designation of a liaison representative.

Activities of the Committee include developing additional materials for District Nurses Associations for recognizing and managing the impaired nurse and follow-up on the Peer Assistance Proposal with Nurses House.

The Committee continues to support clarification regarding the membership status of recovering nurses. ANA's Committee on Bylaws will be meeting briefly during the 1988 ANA Convention. Chairperson Blakeney has indicated that this issue will be considered.

The Committee is in support of Senator Donovan's pending legislation to amend the education law in relation to monitoring licenses during rehabilitation for drug and alcohol abuse. (Attachment)

function of nurses using crack

VI . STATE PRACTICE ISSUES

A. Personal Care Aides - III

The matrix is still not finalized. NYSNA staff have attended two sessions of the field testing. Their impression was that the curriculum was comprehensive and had a logical flow. However, a valid evaluation could not be made since the learners were not the intended audience for the curriculum. All participants were already home health aides, not personal care aides - II.

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COUNCIL ON ETHICAL PRACTICE

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B. LPN Regulations Re: IV Therapy

Justice Paul Cheeseman dismissed the Association's petition on the LPN regulations for a "lack of standing." Since the Association was not granted standing to bring the suit, there was no consideration of the substance or merits. NYSNA's legal counsel has filed an appeal of the standing issue. Also, the article 78 petition has been refiled on behalf of two Association members - Jerold Cohen and Georgia Hebert. Justice Hughes accepted the petition on May 6th. At that time, the Department of Health and the State Education Department's counsel once again raised the issue of standing and claimed that the petitioners are not "at risk." The Executive Director and the Nursing Practice and Services Program were invited to address this issue at the May 6th meeting of LPN educators in Albany. The group was very receptive.

B. Hospital Code Revisions

NYSNA staff attended the April Code Committee hearing where the Nursing Services section was presented. Some Association suggestions for changes in the Code have been incorporated. NYSNA has objected to the inclusion of pharmacists in the verbal order section. The Code Committee directed Department of Health staff to meet with NYSNA, the Pharmacists Association and HANYS to resolve the situation. The Code Committee will be holding a two-day meeting on May 24th and 25th in New York City to accept comments on the Bell Commission Report and those portions of the Code affected by the Report.

D. Labor-Health Industry Task Force

NYSNA members have presented testimony at all hearing sites. A review and analysis of the report was prepared by NYSNA staff and distributed to all interested parties.

VII. OTHER ACTIVITIES

A. NYU - ETC AIDS Workshops

The initial three workshops will be held May 20th and 21st in Albany; May 23rd and 24th in Buffalo; and June 3rd and 4th in Binghamton.

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B. Stress Study

NYSNA staff continue to collaborate with a Texas A&M University researcher on developing a tool to test the stress level of nurses in caring for persons with HIV/AIDS.

Karen A. Ballard
Karen A. Ballard, Director
Nursing Practice and Services Program

Gail K. DeMarco
Gail K. DeMarco, Associate Director
Nursing Practice and Services Program

Louise A. Kehn
Louise A. Kehn, Associate Director
Nursing Practice and Services Program

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5/9/88

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COUNCIL ON ETHICAL PRACTICE

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CLINICAL PRACTICE UNITS Executive Committee

Community Health Nursing

Charlotte Torres, Chairperson
Grace Daly, V. Chairperson
Dorothy Hickey, Mbr. at Lrg.

Gerontological Nursing

Jean Sweeney, Chairperson
Frank De Louise, V. Chairperson
Louise Bedford, Mbr. at Lrg.

Medical-Surgical Nursing

Janet Cadogan, Chairperson
Verlia Brown, V. Chairperson
Ann L. Sedore, Mbr. at Lrg.

Parent Child Health Nursing

Mary Bell-Downes, Chairperson
Irmatrude Grant, V. Chairperson
Joanne Lapidus-Graham, M. at Lrg.

Psy-Mental Health Nursing

Paula Tedesco, Chairperson
Sharon Shisler, V. Chairperson
Kathleen Plum, Mbr. at Lrg.

School Health Nursing

Kathleen Arena, Chairperson
Marion Niblock, V. Chairperson
Genevieve Pollard, Mbr. at Lrg.

COUNCILS Executive Committee

Council on Ethical Practice

Zola Golub, Chairperson
Terri Cavaliere
Patricia Garman
Carol Gavan
Kathleen Nokes

Council on Nursing Practice

Nancy McGinn, Chairperson
Karen Heaphy
Glenda Marshall
Elizabeth Plummer
Anne Skelly

FUNCTIONAL UNITS Executive Committee

Functional Unit of Directors, Associates and Assistants, Managers

Dorothy Richmond, Chairperson
Glenda Marshall, V. Chairperson
Daphne Nelson, Mbr. at Lrg.

Functional Unit of Primary Care Practitioners

Diane Plumadore, Chairperson
Louise Ivan, V. Chairperson
Mary Callan, Mbr. at Lrg.

Functional Unit of Direct Care Practitioners

Vicki Rosenberg, Chairperson
Marva Wade, V. Chairperson
Patricia Gates, Mbr. at Lrg.

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COMMITTEE ON IMPAIRED NURSING PRACTICE

Miriam Aaron, Chairperson
Susan Bender (representative of NYSANA)
Brenda Haughey
Ada Michaels (representative of LPNTNY, Inc.)

Susan Kemble
Georgine McCabe
Karen Wolcott

KAB/kac
5/9/88

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COUNCIL ON ETHICAL PRACTICE

STATE OF NEW YORK

7137

IN SENATE

February 22, 1988

Introduced by Sen. DONOVAN -- read twice and ordered printed, and when printed to be committed to the Committee on Alcoholism and Drug Abuse

AN ACT to amend the education law, in relation to monitoring licenses during rehabilitation for drug and alcohol abuse

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

- 1 Section 1. The education law is amended by adding a new section
- 2 sixty-five hundred ten-c to read as follows:
- 3 § 6510-c. Monitoring of licenses during rehabilitation for drug and
- 4 alcohol abuse. 1. A licensee who abuses alcohol or other drugs who may
- 5 not be incapacitated for the active practice of a profession licensed
- 6 pursuant to article one hundred thirty-one or article one hundred
- 7 thirty-one-B of this chapter, and whose drug or alcohol abuse has not
- 8 resulted in harm to a patient or client, may voluntarily agree to moni-
- 9 toring by the department while undergoing treatment or rehabilitation.
- 10 The agreement to be monitored shall not be deemed to be an admission of
- 11 disability or of professional misconduct, and shall not be used as evi-
- 12 dence of a violation of subdivision three or four of section sixty-five
- 13 hundred nine of this subarticle, unless the licensee violates the condi-
- 14 tions of the monitoring. Agreement to monitoring under this subdivision
- 15 shall not bar any disciplinary action except action based solely upon
- 16 the provisions of subdivision three or four of section sixty-five hun-
- 17 dred nine of this subarticle, and only if no harm to a patient has
- 18 resulted, and shall not bar any civil or criminal action or proceeding
- 19 which might be brought without regard to such agreement. Monitoring will
- 20 terminate when the licensee has completed rehabilitation and has proven
- 21 the ability to practice.
- 22 2. The committee on drug and alcohol abuse shall advise the board of
- 23 regents on matters relating to practice by professional licensees with
- 24 drugs or alcohol abuse problems, and shall administer the provisions of
- 25 this section. The committee shall recommend to the board of regents such
- 26 rules as are necessary to carry out the purposes of this section. In-

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [] is old law to be omitted.

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COUNCIL ON ETHICAL PRACTICE

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1 cluding but not limited to procedures for the submission of applications
2 for monitoring, for the determination of the suitability of the licensee
3 for the program, and for the referral of cases for investigation or
4 prosecution pursuant to section sixty-five hundred ten of this subarti-
5 cle if a licensee fails to comply with the conditions of an approved
6 program of treatment and monitoring. Determinations by the committee
7 relating to licensees shall be made by panels of at least three members
8 of the committee designated by the executive secretary, who shall also
9 designate a member of the state board for the licensee's profession as
10 an ex-officio nonvoting member of each panel.

11 3. Application for participation in the monitoring program pursuant to
12 this section shall be submitted to the committee, and shall identify a
13 proposed rehabilitation program, and shall include a consent to the
14 release of all information concerning the licensee's treatment to the
15 committee. All information concerning an application other than partici-
16 pation in the program and the successful completion or failure of or
17 withdrawal from the program, shall be strictly confidential, and may not
18 be released by the committee to any person or body without the consent
19 of the licensee. The immunity from disciplinary action conferred by this
20 section shall be conditioned upon the approval of the rehabilitation
21 program by the committee and its successful completion by the applicant.
22 Approval of a rehabilitation program by the committee shall not consti-
23 tute a representation as to the probability of success of the program or
24 any assumption of financial responsibility for its costs.

25 § 2. This act shall take effect on the sixtieth day after it shall
26 have become a law.

MEMORANDUM FOR THE SENATE

S. 7137

COMMITTEE ON EDUCATION

MEMORANDUM IN SUPPORT OF "AN ACT TO AMEND THE EDUCATION LAW IN
RELATION TO MONITORING OF LICENSEES DURING REHABILITATION FOR
DRUG AND ALCOHOL ABUSE."

Purpose of the bill:

To permit a licensee who abuses alcohol or other drugs, but
is not incapacitated, to be monitored by the State Education
Department while undergoing treatment.

Summary of the provisions of the bill:

This bill would add a new section 6510-a of the Education
Law to allow licensed professionals who abuse alcohol or other
drugs to continue to practice in certain controlled, closely
supervised circumstances.

Statement in support of the bill:

Section 6510(b) of the Education Law, enacted in 1985,
allows a licensed professional who is impaired by the use of
alcohol or other drugs to voluntarily surrender his or her
license while undergoing treatment or rehabilitation. The
licensee is granted immunity from disciplinary action in certain
limited circumstances. The intention of the legislation is
strongly supported by licensed professionals and others.
Realistically, however, the program has not worked as well as it
should because licensed professionals are extremely reluctant to
surrender their licenses.

Licensed professionals fear that if they surrender the
license it will not be returned for years, if ever. Hospital,
labor union representatives, directors of nursing and other
advocates who are trying to assist a colleague or employee, as
well as individual licensees who inquire about the program, state
that surrender is the main reason that people do not participate.
But, it is clear that at least ten percent of our licensed
professionals abuse or are addicted to alcohol or other drugs.

Not all individuals who abuse alcohol or other drugs need to
stop working while they undergo treatment. In fact, for certain
persons it may be counterproductive. This proposal would allow
the committee for drug and alcohol abuse to decide whether an
individual must surrender the license. In some instances, the
licensee could continue to work while being closely monitored.

The legislation would make this process more attractive to
the licensed professional and thereby protect the public. This
modification should encourage the professional to come forward in
the early stages of his or her disease. It will enable profes-
sionals to urge their colleagues to seek help before they are
totally addicted. Clearly, any measure that reduces the number
of abusing or impaired professionals who are practicing is
beneficial to the public.

Budgetary implications of the bill:

If this legislation substantially increases the number of
applicants that the committee on drug and alcohol abuse must
consider, there will be some additional costs for the committee
expenses. The committee also is that of licensees and other
related, closely supervised procedures and costs.